

Community Choices Waiver Provider Training

Complaints, Corrective Action, and Adverse Actions



Wyoming Department of Health
Division of Healthcare Financing
Home and Community-Based Services Section



HOME AND
COMMUNITY-
BASED
SERVICES

Welcome to the Division of Healthcare Financing, referred to as Division, Home and Community-Based Services Section provider training covering Community Choices Waiver complaints, corrective action, and adverse actions. I am Certification and Credentialing Specialist, Lisa Ashland, from the Provider Support Unit. Thank you for joining us today.

Purpose of This Training

To introduce the
Complaint, Corrective
Action, and Adverse
Action Processes

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The purpose of this training is to introduce the process for complaints, corrective action, and adverse actions for Community Choices Waiver, or CCW, providers. Throughout this training we will use the term Provider, which includes case management agencies. This training will outline the processes for complaints that are submitted to the Home and Community Based Services Section, which we will refer to as the HCBS section, and will also provide best practices for providers when it comes to complaints within their own organizations.

Training Agenda

- Examine complaints
- Explain the purpose and process for corrective action and corrective action plans
- Discuss the purpose and process for adverse actions
- Review requirements and expectations of the Division

Today's training agenda begins with complaints. We will examine the who, what, when, why, and how of complaints and how the HCBS Incident Management Specialists, or IMS, team will respond. Next we will discuss what happens when complaints are substantiated and require corrective action. What is corrective action? Don't worry - we will explain corrective action and provider requirements for corrective action plans. During previous trainings we have discussed adverse actions and how they may result from CCW certification renewals. Today we will discuss how adverse action may apply to complaints and incidents. Finally, we will wrap up today's training by reviewing the requirements and expectations that the Division has of providers when it comes to complaints, corrective actions, and adverse action.

Agreeing to the Rules



- Provider Agreement requires the providers follow Medicaid Rules
 - Chapter 1: Definitions
 - Chapter 4: Medicaid Administrative Hearings
 - Chapter 16: Medicaid Program Integrity
 - Chapter 34: Home & Community Based Waiver Services (*Under review*)

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As a Medicaid waiver provider, you have signed the Medicaid Provider Agreement. The Medicaid Provider Agreement, which we will refer to as the Provider Agreement, has previously been covered in a separate Division training, but it is important to provide this reference reminder. Medicaid providers are bound to the Wyoming Medicaid Rules when the provider agreement is signed.

This training will review some of the requirements outlined in Wyoming Medicaid Rule Chapters 1, 4, 16, and 34.

Chapter 1 will provide definitions for terms used in this training.

As a Medicaid provider, you have the right to request administrative review, also known as an administrative hearing, if or when an adverse action is taken that affects you or your organization. Chapter 4 of Wyoming Medicaid Rules establishes the Medicaid administrative hearing process and the adverse actions that would permit a hearing request.

Chapter 16, titled Medicaid Program Integrity, will be referred to in this training as it relates to Medicaid required audits of provider records, investigations of fraud, waste, and abuse, as well as Medicaid allowable adverse actions.

Chapter 34, titled Home and Community Based Waiver Services, is the current chapter authority for the CCW. It is presently under revision. Stay tuned for more on Chapter 34!



Before we get too far into the discussion about your responsibilities as a provider, let's take a moment to discuss the real reason we are here, attending this training today. A theme throughout all of the Division's provider trainings is the fact that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. The individuals served by the CCW are adults, with the same rights as you and I.

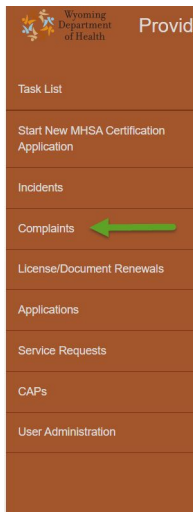
CCW participants and their families have the right to choose their providers, their services, and to voice concerns and have those concerns addressed timely and appropriately. When necessary, the Division will give guidance to the provider about these concerns if they identify issues of non-compliance. The Division is obligated to take additional measures when the complaint or compliance concern is a threat to the health or safety of a participant, violates the rights of participants, or does not align with HCBS requirements and Medicaid Rules.



Let's be honest - complaints can be frustrating and time consuming for everyone. Whether you are the person with the complaint or the person responding to the complaint, it is safe to say that no one enjoys complaints. However, responding to complaints is all in a day's work as a service provider. From small complaints about menu options or the room temperature to complaints about more significant concerns that affect a participant's right to have visitors or refuse services, all complaints can be an opportunity to improve your relationships and service delivery. As a best practice, providers should offer a venue for complaints to be made and responded to. Participants and their families need to have the opportunity to report concerns directly to the provider, as well as Home and Community-Based Services, or HCBS, Section staff.

As we continue to discuss the purpose and process for complaints, please remember that the HCBS Section is happy to assist with any questions or concerns that may pertain to the CCW and Medicaid rule. The HCBS Section's scope of authority is outlined in the Centers for Medicare and Medicaid Services or CMS approved waiver agreement and the Wyoming Medicaid rules. Concerns reported that fall outside of HCBS Section scope may be referred to other agencies as needed for resolution. The HCBS Section is not available to mediate issues between providers, case managers, or other stakeholders. The expectation for all waiver providers and case managers is to act professionally and work together for the common goal of providing the participant with the highest quality services available.

Submitting Complaints in WHP



New to the Wyoming Health Provider (WHP) portal

The screenshot displays the 'Open Complaint Submissions' page. At the top, there is a button labeled '1 Submit a New Complaint'. Below this, the section '2 Open Complaint Submissions' contains a table with the following data:

Complaint	Participant	Event Date	Current Status
Complaint Submission 1027	C [REDACTED] D [REDACTED]		Pending initial entry by reporter

Below the table, the section '3 Closed Complaint Submissions' shows a message: 'No closed complaint submissions found'.

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You may have noticed some recent changes in the Wyoming Health Provider portal, which we will refer to as WHP. On April 6th, “Complaints” was added to the left hand navigation bar. If you click on “Complaints,” you will open the complaints page. Our WHP system developers and the HCBS Section staff have created a step-by-step guide to walk providers through a complaint submission. This guide is located on the *Technical Guidance* tab of the [HCBS Document Library](#), along with a brief demonstration video.

Submitting a complaint in the WHP has the benefit of linking the appropriate participant to the complaint with just a quick search, and pre-populating the reporting provider’s information. The complaint process in WHP is intended to be user-friendly and intuitive. Reporting providers will be able to create the complaint, upload supporting evidence or documentation, and submit the complaint directly to the IMS for review and response. This online reporting process will be familiar to those providers who have submitted incidents through the WHP.

Complaints submitted by people who are not registered in the WHP should continue to be submitted by selecting the Complaints button on the [homepage](#) of the HCBS Section website. Step by step instructions for complaint submissions through the website are included in the Technical Guidance for Complaint Submissions on the *Technical Guidance* tab of the [HCBS Document Library](#).

Why file Complaints?

- Advocate for participants; Support them in reporting concerns
- Improve HCBS operations by identifying trends
- Improve relationships and inspire growth



The participants supported by the CCW fall into the category of vulnerable adults, and in truth they might be. However, it is important that we recognize that CCW participants are adults who have made decisions about their care, their health, and their settings long before becoming a waiver participant. No different than you or I, participants must have an opportunity to express their concerns or frustrations with their services, their treatment, their settings, and other issues that may crop up regarding waiver services. It is the job of the Division and CCW providers to listen to the complaints and review the possible solutions to the benefit of the participant. Working with a participant to understand the complaint, the root of the issue, and find a solution can go a long way. We should all encourage and support participants in voicing their concerns.

The HCBS Section has a duty to assist with the improvement of the CCW program. There is no better place for us to begin than reviewing and resolving complaints. Oftentimes one person's concern or issue is the same as another person's. Part of the overall complaint process is monitoring the program wide concerns and trends. It is through the complaints process that systemic issues can be identified and resolved.

For example, you may have experienced a technical issue with the Electronic Medicaid Waiver System (EMWS), the WHP, or the website. These issues are reviewed, verified, tested, and eventually resolved because they were reported. Sometimes little improvements can go a long way in overall program improvement. This is not only important for the HCBS section to keep the program going, but ultimately to make the waiver function better as a whole.

Providers have the same opportunities for improvement by developing and implementing policies and procedures for complaint resolution. When you understand the importance of collecting, reviewing, and mitigating participant complaints you have the opportunity to improve not only your own day to day, but also the relationships with the participants you serve, their families, and the provider community. When complaints can be resolved timely and satisfactorily, everyone wins and an unpleasant situation can turn into a positive experience.

REMEMBER!

The Wyoming Adult Protective Services Act (W.S. §35-20-101) requires that, "any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services."

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Just as a reminder:

The Wyoming Adult Protective Services Act, Wyoming Statute Title 35, Section 20, 101, requires that, "any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services."

You may also recall from the Critical Incident Reporting training that case managers and waiver service providers must report critical incidents through the Division's web-based reporting system as soon as practicable after assuring the health and safety of the participant.

This is important when determining when and how to file a complaint with the HCBS Section. In general, critical incidents must be filed when the incident involves any type of abuse, intimidation, neglect, exploitation, unexpected death, use of restraint, and unauthorized restrictive interventions. Complaints typically involve concerns or issues with how services are being delivered, additional costs or requirements of service delivery, and other concerns regarding the activities or processes of a provider, participant, or even the HCBS Section. If you are unsure if a scenario is best reported as an incident or as a complaint, a best practice is to reach out to the IMS assigned to your county for help.

Elements of the Complaint



- Include details:
 - Contact information
 - Specific dates and times
 - Steps taken to resolve concerns
 - Documentation supporting the complaint
- Participant centered
 - Not focused on provider issues, but how it affects the participant.

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For the purposes of today's training we will focus on the importance of the complaint's content. In order to assist the IMS with processing the complaint it is important to include as much information as possible. The information provided should include contact information for you as the reporting provider, the participant when appropriate, and as much detail about the event as possible. Let's consider the following example:

Penny is the case manager for Mario. Mario lives at Miracle Meadows assisted living. During Mario's residency at Miracle Meadows his health has declined and he has become less active in Miracle Meadows' and community activities, spending more time in his room. Penny has previously filed a complaint with Miracle Meadows regarding the cleanliness of Mario's room. Her specific concerns reported included trash removal not being conducted regularly or frequently enough and that his bedding was not being changed weekly as outlined in Mario's service plan due to his skin condition. This is the 3rd face-to-face visit that Penny has noted overflowing trash and unchanged bedding. After asking Mario about his service, Penny sends an email to Miracle Meadows' administration who advises that they are understaffed. Miracle Meadows apologizes and states they will take care of it as soon as possible. Penny is concerned that Mario will continue to receive services that are not meeting his needs. Penny recognizes that Miracle Meadows is not following Mario's service plan and submits her complaint to the HCBS Section.

Penny logs in to the WHP and completes the complaint form, identifying Mario as the participant affected. Penny's complaint focuses on Mario and the events surrounding her concerns. She includes her cell phone number, her email address, and Mario's

phone number. She provides the days and times she notified Miracle Meadows of her concerns, the responses provided in those moments, and her ongoing concerns. Penny includes some details that Mario has provided regarding when his bedding is usually changed and his trash is picked up. Penny is not mad at Miracle Meadows. The complaint is not malicious or bad spirited. Penny makes the report of the facts, and does not include her opinions regarding the provider or their services. Penny can understand the short staffing issues, but that does not negate her responsibility to Mario. In fact, Penny is hopeful that by filing her complaint, Miracle Meadows will be offered some additional resources for improving their services for Mario.

Should Penny have filed a complaint? Absolutely. Penny is advocating for the rights and health of Mario. She has attempted to resolve her concerns through complaints directly to Miracle Meadows and has not been provided a satisfactory response. Penny contacts Mario's family to discuss her concerns and the options of other providers who can better meet Mario's needs in addition to formally filing her complaint with HCBS.

Processing Complaints

IMS Determines

- Immediate threat to participant's health & safety
 - If yes, makes immediate necessary contacts
- Within HCBS authority
 - If no, close complaint with notification

IMS Sends Notification to Reporting Party & Provider

- When complaint is under review
- When additional information is required
- When complaint is closed (resolved)

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Complaints reported to the HCBS Section are reviewed and investigated through a process that is very similar to the critical incident review process. We have previously conducted training covering critical incident reporting. For reference, the recorded incident management training is available on the HCBS Section [Training page](#).

Upon submission of a complaint, the assigned IMS will first determine if the complaint is an immediate threat to the health or safety of the participant. If the IMS determines there is a threat to the well-being of the participant, the IMS will take the necessary immediate actions. These actions may include, and are not limited to, contacting the participant, their legally authorized representative or LAR, the participant's case manager, the reporting party, law enforcement, or Adult Protection Services or APS. The IMS is obligated to share pertinent information with agencies such as APS and law enforcement for the purposes of complaint investigations.

If the IMS determines that the complaint is not within the scope of the HCBS Section or Medicaid, the IMS sends notification to the reporting party. This notification will provide information regarding the authority of the HCBS Section and provide additional resources to resolve the complaint. For example, an IMS receives a complaint regarding an LAR restricting a participant from driving their vehicle. The HCBS Section is unable to enforce Medicaid regulations for the LAR. This scenario falls outside of the scope of authority for the HCBS Section. The IMS will provide notice to the reporting party that it is not within the scope and recommend that the reporting party file their concerns with APS, law enforcement, or the Ombudsman. The Long Term Care Ombudsman investigates, advocates, and mediates on behalf of

adults applying for or receiving long term care services in order to resolve complaints concerning actions or inactions that may adversely affect participant health, safety, welfare or rights. Following an investigation, the Ombudsman reports findings and recommendations to the participant or participant's LAR and may report the findings to any other entity deemed appropriate.

If the IMS determines the complaint is not a threat to the health and safety of the participant but is within the scope of the HCBS Section, the IMS will continue processing the complaint by sending notification to the provider that is the subject of the complaint. This notice will include a summary of the concerns and the participant involved, but will not disclose the reporting party. It is not an HCBS policy to release the name of the reporting party. The notices may include a request for additional information or documentation, and will include a deadline for the additional requested information to be received.

Once the IMS has gathered and reviewed the necessary information pertaining to the complaint, a decision to substantiate the complaint or not must be made. If the IMS review finds there are no rule compliance issues or violations of regulatory policies or processes, the complaint will be closed. The IMS will provide written notice of the outcome to the reporting party and the provider who was reported.

Corrective Action



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We know that not all complaints can be resolved satisfactorily or sometimes even resolved at all. It's important to recognize that some complaints are rooted in personality differences or biases. In cases of discord between individuals or organizations regarding professional or personal differences, the HCBS Section will not mediate. The HCBS Section has a scope of authority which includes the delivery of waiver services and participant rights. As professional service providers it is important that a professional demeanor and practices are always employed.

This is an important thing to consider as we venture into our next topic which is corrective action. Corrective action is one outcome of non-compliance to HCBS Section policy or Medicaid Rule. Typically, corrective action issued by the HCBS Section can be a result of the certification renewal process, critical incident actions or inactions, or a substantiated complaint.

When the HCBS Section issues corrective action, we have identified provider non-compliance and will require a response from the provider by way of a corrective action plan. As we continue to discuss corrective action we want to remind you that this process is not meant to be a punishment or threat of further action. Instead, we want to treat it as an invitation to collaborate on a plan to return to compliance as necessary. There is no room in the corrective action process for argument and discord; only growth and improvement.

What is Corrective Action?

- **Corrective Action:**

Division's written notice of concerns of non-compliance with HCBS Section or Medicaid regulations.

- **Corrective Action Plan (CAP):**

Plan of action developed by the provider to achieve targeted outcomes of identified non-compliance in an effort to eliminate repeated deficient practices.

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CCW providers may receive corrective action as a result of non-compliance with HCBS Section or Medicaid regulation. Corrective action may be necessary as a result of incomplete or inadequate documentation, provider policies and procedures that do not align with HCBS Section or Medicaid regulations, practices that do not support the participant's health and well-being, and other similar concerns. Corrective action is the Division's way of notifying the provider that such concerns exist and an invitation to develop a plan to comply with HCBS and Medicaid Regulations. Corrective actions are not adverse actions, which we will discuss more in-depth later in this training.

Upon identification of non-compliance, providers are expected to participate in returning to compliance through a corrective action plan, or CAP. A corrective action plan is developed by the provider and explains how they are going to fix identified problems and keep them from happening again. What does this mean? What does this look like? Let's check on our Miracle Meadows example.

After reviewing the complaint Penny submitted, IMS Luigi sent notification to Penny and Miracle Meadows that the complaint was under review. Luigi requested Miracle Meadows' policies and procedures regarding staffing, housekeeping, and trash, as well as schedules and documentation of services. Luigi reviewed Mario's service plan and Penny's Case Management Monthly Review forms (CMMRs). Luigi identified that Miracle Meadows was not meeting Mario's needs as outlined in his service plan, and Miracle Meadows was not following its own policies - due to their lack of staff. Luigi sends corrective action notification to Miracle Meadows. In the notification, Luigi explains that Miracle Meadows is in violation of HCBS requirements for

person-centered services, and is in violation of its own staffing policies. Luigi requests that Miracle Meadows submit a CAP to demonstrate their plan to come into compliance with HCBS regulation and provide an accurate policy and procedure for the organization.

Corrective Action Plan (CAP)

Area of Non-Compliance	Action Step	Responsible Party	Due Date (2022)
Failure to provide services as outlined in Plan of care (CCW agreement & HCBS regulation for person centered service)	(1) Review staffing to ensure all participant needs are met	(1) Daisy, Director	(1) June 5
	(2) Hire more staff	(2) K. Troopa, HR	(2) Sept 1
	(3) Contract additional services to meet participant needs	(3) Bill, Contract specialist	(3) June 15
Policies and procedures are not accurate	Review and update policies and procedures	Daisy, K, and Bill	June 30

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When the Division imposes corrective action on a provider, the provider must develop and submit a CAP that explains the steps they will take to make the necessary corrections. The CAP must adequately address the area of non-compliance, and include detailed action steps the provider will take to ensure the correction is made now and in the future, the person responsible for ensuring the correction is made, the date by which the correction will be made, and the actual date of completion.

As you can see, Miracle Meadows has planned to make some changes and updates. In regards to their inability to deliver the services as outlined in the service plan, Miracle Meadows will conduct a review and adjustment of current staffing, hire more staff, and contract with other professionals to ensure they meet the needs of the participants they are serving as needed. Each of those steps has an assigned responsible party and due date that Miracle Meadows has determined is most appropriate. Additionally, the team will be reviewing the policies and procedures and updating them as needed.

A CAP must be submitted to the HCBS Section for review and acceptance. If the action steps listed in the CAP do not appropriately or adequately address the non-compliance, the CAP will be sent back to the provider for review and update. The provider will receive an explanation for the return of the CAP.

For example: Luigi may want more explanation about what “Review staffing to ensure all participant needs are being met” actually means. Does this mean the provider will be realigning schedules, offering overtime to its employees, or possibly providing

participants with a notice to discontinue services because Miracle Meadows is unable to meet their needs? Luigi would send notification that the CAP was received and reviewed, but not accepted due to his outstanding questions. Luigi will assign a new due date for the CAP to be submitted and accepted. Once the information is provided and the updated CAP is received and reviewed, Luigi accepts the updates as sufficient.

CAPs remain open until proof of implementation is verified. What does that mean? The HCBS Section will follow up with the provider on the due dates provided in the CAP to ensure the plan has been successfully implemented. This verification will result in a closure of the action steps. Once all action steps are completed and verified, the CAP will be considered closed.

If a CAP is not implemented or the non-compliance becomes a pattern or trend for the provider, adverse actions may be a necessary next step.

Adverse Actions



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Wyoming Medicaid Rule, Chapter 1 defines adverse actions as “the termination, suspension or other sanction of a provider, the denial or withdrawal of admission certification, or the denial or reduction of a Medicaid payment to a provider.” As we continue to discuss adverse actions, it is important to look back at corrective action and embrace that corrective action is a transaction between the Division and a provider organization, when non-compliance with rules or regulation is identified and a plan is created to resolve the issue.

Corrective action results in a CAP. The outcome of a successful CAP is a return to compliance. When a CAP is not provided, not adequate, or not implemented appropriately the HCBS Section cannot continue to provide notice of corrective action. To delay a return to compliance can mean a delay in providing high quality services to participants. Adverse action is an escalation of non-compliance beyond a simple plan to restore compliance. Adverse actions are a formal process as covered in Medicaid Rule and can have considerable consequences for waiver providers.

Imposing Adverse Actions

Things that must be considered:

- The nature and extent of the provider's violations;
- The provider's history of previous violations;
- Actions taken or recommended by other State regulatory or licensing agencies; and
- The steps taken by the provider to reduce the possibility of future violations.



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So far we have said adverse actions are an escalation of non compliance and a formal process, but what are they? Adverse actions are covered in Wyoming Medicaid Rule Chapter 16, section 12. This section of Medicaid rule outlines when the Division can impose adverse actions, what should be taken into consideration when imposing an adverse action, how a provider is notified of adverse action, who else must be notified of adverse action, and the effective date of adverse actions.

While there are a wide variety of reasons for adverse actions, for the purposes of this training we are going to focus on subsection (21): "Failure to submit an acceptable corrective action/quality improvement plan, or has failed to implement the corrective action/quality improvement plan approved by the Department."

In very few circumstances will the Division jump right to an adverse action. The things that must be considered when imposing adverse actions are:

- The nature and extent of the provider's violations;
- The provider's history of previous violations;
- Actions taken or recommended by other State regulatory or licensing agencies; and
- The steps taken by the provider to reduce the possibility of future violations.

By considering the nature and extent of the rule violations, as well as the provider's history of rule violations, the HCBS Section intends to be fair and supportive of the provider's ability to continue to provide services safely and appropriately.

The HCBS Section must also consider any actions that have been taken or recommendations that have been made by other State agencies, such as the Division of Aging. This is in part to ensure that the provider maintains the necessary licensure required to remain a service provider, and help avoid complicating factors that may be imposed by the other agencies. For example, if the Division of Aging revokes Miracle Meadow's ALF license, Miracle Meadows would no longer be able to remain certified to provide waiver services.

Finally, the Division must consider the provider's willingness to come into compliance with Rule. If the provider has failed to address rule violations in the past, this is an indication that adverse action may be warranted in future instances. As we discussed during complaints, the HCBS Section monitors complaints and other reports for trends or patterns of on-going issues or non-compliance. If a provider has a pattern of noncompliance, adverse actions may be necessary to correct the pattern.

Many Adverse Action Options

- Educational interventions;
- Recovering overpayments;
- Suspending provider payments;
- Suspending or terminating the provider agreement;
- Placing conditions on a provider;
- Imposing a monitor or civil monetary penalties;
- Immediately suspending a provider's certification; or
- Any other additional and appropriate adverse actions.

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There are several adverse actions that can be imposed on a provider, including:

- Educational interventions;
- Recovering overpayments;
- Suspending provider payments;
- Suspending the provider agreement;
- Terminating the provider agreement;
- Placing conditions on a provider;
- Imposing a monitor;
- Imposing civil monetary penalties;
- Immediately suspending a provider's certification; or
- Any other additional and appropriate adverse actions.

These actions are explained in Chapter 16, Section 12 (c).

It is important here that we clarify that corrective action is not an adverse action and does not fall into the last category of adverse actions; other additional and appropriate adverse action. The Division wants to offer creative and fair solutions for providers when compliance issues are identified. Sometimes this might require changing business practices or making additional adjustments as part of an adverse action.



Best Practices

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As a CCW provider, we want you to have the skills necessary not only to support the participants of the CCW, but also to be successful in the relationship with the HCBS Section. You should want to continue to learn and grow as an organization, reviewing common issues and identifying all possible solutions. The HCBS Section should be considered a source of information and an ally in locating resources to serve the HCBS program and the community to the best of our ability.

Let's discuss some best practices to ensure complaints, corrective action, and adverse action can be addressed and resolved quickly and effectively.

Best Practices

- Communicate with the Division
- Be transparent
- Be prepared and willing to make suggested changes
- Be able and willing to demonstrate changes or updates to policies, procedures, and practices
- Document everything!



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As a partner with our CCW providers, we want to be able to offer you some best practices to incorporate into your policies and procedures. Our suggestions include:

Communicate with the Division -This is CRUCIAL to a good working relationship. Feel free to reach out to the Certification and Credentialing team when you have questions about documentation, billing, service requirements, or anything else regarding your certification or the renewal process. The IMS assigned to your county is also a great resource for you, especially if you have questions about how to handle a complaint or an incident and rule or process for complaints or incidents. The Benefits and Eligibility Specialist, or BES, assigned to your county is a valuable resource when it comes to plans of care, eligibility criteria, and the processes that most affect participants, particularly for CCW case managers. We know that communication is key and we strive to provide answers and information as it is necessary, sometimes it may take some research on our end to get to those answers - but we strive to provide CCW providers and case managers the best customer service possible.

Be transparent - It is also important to be upfront with the information to the Division. As we discussed with complaints, oftentimes if you are struggling with information or processes, so is someone else. The Division strives to be as transparent as possible at all times. Of course, during investigations into complaints some information will not be available, but outside of those situations, providers have the right to ask questions and get answers. Providing details and information will assist Division staff in being able to accurately answer questions. The CCW can be a place where confusion may

occur and we get that. Let's work together to have a clear picture and consider all resolutions.

Be prepared and willing to make changes - Change is hard and it seems like we are constantly changing. Change is necessary to continue to grow and be a better program providing services to a vulnerable population. The intent of investigating complaints, creating CAPs, and even adverse actions should never be considered a punishment or threat. These processes are necessary to identify issues, concerns, and shortcomings. These processes support growth through change.

Be able and willing to demonstrate changes - Take some credit! When change is hard and you put in the work, be proud to show it! How can we get from good to better to best without being able to see where it started? We can't say it enough, change is hard! Be proud to show where it started and how it's going!

Document everything - We cannot stress how important documentation is. If it isn't documented, it didn't happen. Keep your records, be organized, and know that if your policy or procedure is in question - you can change it. Policies and procedures should be reviewed on an annual basis to ensure they are appropriately depicting how your organization operates. Good documentation practices can make responding to complaints, corrective action, and adverse actions easier when you can provide evidence of the problem and the solution.



Key Takeaways



1. Complaints are opportunities for improvement.
2. Corrective action is an invitation to make a plan to return to compliance. Not an adverse action.
3. Adverse actions are an escalation of non-compliance issues.
4. Providers are an important part of the HCBS program. Working together we can improve HCBS.

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As we bring today's training to a close, we want to discuss the key takeaways from this presentation.

First, complaints are no fun. It's extra work for everyone, but it also provides all of us an opportunity for growth and a valuable resource for improvement. Complaints are important for identifying trends and issues that can be resolved to improve processes and service delivery. Together, we can make complaints positive experiences and watch the CCW keep getting better.

Number two, corrective action is an invitation to improve. When the Division provides you with corrective action, take advantage of the opportunity to learn more and grow into a provider with the highest quality services. You make the plan, together we can make sure the plan is implemented, and see how far we can grow. Attempting to argue and point fingers through a CAP is no way to approach it; there is only room for growth in a corrective action plan.

Number three, adverse actions are an escalation of a corrective action. Adverse actions can mean that the corrective action plan has not been followed or implemented and must be taken to the next phase to resolve the issue.

Finally, you are important to the HCBS Section. Providers are a part of the CCW program. Together with the HCBS Section and our participants we can grow, learn, and improve CCW for everyone.

Questions???

Credentialing team:

wdh-hcbs-credentialing@wyo.gov

or

Your assigned Incident Management Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

Thank you for joining us for today's training. If you have any questions or concerns we would be happy to address them now in the chat, otherwise please contact the Certification and Credentialing team or the Incident Management Specialist assigned to your area.